Medical Care Advisory Committee

Minutes of Meeting September 19, 2013

In Attendance

Committee Members Present: Lincoln Nehring, Russ Elbel, Andrew Riggle, Debra Mair, Jackie Rendo, Michelle McComber, Earl (David) Ward (by phone), Tina Persels, Kevin Burt, Mark Brasher, Michael Hales

Committee Members Excused: Mauricio Agramont, Steven Mickelson, Jason Horgesheimer, Greg Myers

Committee Members Absent: Warren Walker, Matthew Slonaker, LaVal Jensen

Staff Present: Emma Chacon, Gail Rapp, John Curless, Craig Devashrayee, Jeff Nelson, Tracy Luoma, Nate Checketts, Kim Michelson, Tonya Hales, Teresa Garrett, Josip Ambrenac, Summer Perkins

Visitors Present: Kris Lawson, Joyce Delcourt, Barb Viskochil, Nalani Namauu, William Cosgrove, M.D., Mark Ward, Beau Colvin, Sage Winchester, Patrick Fleming, Jeannie Edens, Joan M. Gallegos, John Borer, Lee Moss

Welcome

Chairman Nehring welcomed everyone and called the meeting to order at 1:37 p.m.

Minutes

Andrew moved to approve the minutes of the meeting held August 15, 2013. The motion was seconded by Jackie and passed.

New Rulemakings

Craig Devashrayee presented the new rulemakings. There were no questions from the committee or the audience members.

Rule; (What It Does); Comments.	File	Effective
R414-1-5 Incorporations by Reference; Subsection 26-18-3(2)(a) requires the Medicaid program to implement policy through administrative rules. The Department, in order to draw down federal funds, must have an approved State Plan with the Centers for Medicare and Medicaid Services (CMS). The purpose of this change, therefore, is to incorporate the most current Medicaid State Plan by reference and to implement by rule both the definitions and the attachment for the Private Duty Nursing Acuity Grid found in the Home Health Agencies Utah Medicaid Provider Manual, and to implement by rule ongoing Medicaid policy for services described in the Medical Supplies Utah Medicaid Provider Manual; Hospital Services Utah Medicaid Provider Manual with its attachments; Speech-Language Services Utah Medicaid Provider Manual; Audiology Services Utah Medicaid Provider Manual; Hospice Care Utah Medicaid Provider Manual; Long Term Care Services in Nursing Facilities Utah Medicaid Provider Manual; Personal Care Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Individuals 65 or Older Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Acquired Brain Injury Age 18 and Older Utah Medicaid Provider Manual; Utah Home	**9-10-13**	**11-7-13**

and Community-Based Waiver Services for Individuals with Intellectual Disabilities or Other Related Conditions Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Individuals with Physical Disabilities Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services New Choices Waiver Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services for Technology Dependent, Medically Fragile Individuals Utah Medicaid Provider Manual; Utah Home and Community-Based Waiver Services Autism Waiver Utah Medicaid Provider Manual; Office of Inspector General Administrative Hearings Procedures Manual; Pharmacy Services Utah Medicaid Provider Manual; Coverage and Reimbursement Code Look-up Tool; Certified Nurse – Midwife Services Utah Medicaid Provider Manual; CHEC Services Utah Medicaid Provider Manual with its attachments; Chiropractic Medicine Utah Medicaid Provider Manual; Dental Services Utah Medicaid Provider Manual; General Attachments for the Utah Medicaid Provider Manual; Indian Health Utah Medicaid Provider Manual; Laboratory Services Utah Medicaid Provider Manual with its attachments; Medical Transportation Utah Medicaid Provider Manual; Mental Health Centers/ Prepaid Mental Health Plans Utah Medicaid Provider Manual; Non-Traditional Medicaid Health Plan Utah Medicaid Provider Manual with its attachments; Certified Family Nurse Practitioner and Pediatric Nurse Practitioner Utah Medicaid Provider Manual; Oral Maxillofacial Surgeon Services Utah Medicaid Provider Manual; Physical Therapy and Occupational Therapy Services Utah Medicaid Provider Manual; Physician Services and Anesthesiology Utah Medicaid Provider Manual with its attachments; Podiatric Services Utah Medicaid Provider Manual; Primary Care Network Utah Medicaid Provider Manual with its attachments; Psychology Services Utah Medicaid Provider Manual; Rehabilitative Mental Health and Substance Use Disorder Services Utah Medicaid Provider Manual; Rehabilitative Mental Health Services for Children Under Authority of Department of Human Services, Division of Child & Family Services or Division of Juvenile Justice Services Utah Medicaid Provider Manual; Rural Health Clinic Services Utah Medicaid Provider Manual with its attachments; School-Based Skills Development Services Utah Medicaid Provider Manual; Section I: General Information of the Utah Medicaid Provider Manual; Services for Pregnant Women Utah Medicaid Provider Manual; Substance Abuse Treatment Services & Targeted Case Management Services for Substance Abuse Utah Medicaid Provider Manual; Targeted Case Management for CHEC Medicaid Eligible Children Utah Medicaid Provider Manual; Targeted Case Management for the Chronically Mentally Ill Utah Medicaid Provider Manual; Targeted Case Management for Early Childhood (Ages 0-4) Utah Medicaid Provider Manual; and Vision Care Services Utah Medicaid Provider Manual (Updates to October 1, 2013).		
R414-42 Telehealth Home Health Services (Five-Year Review); The Department will continue this rule because it provides telehealth home health services for Medicaid recipients, spells out the eligibility requirements for these services, and establishes reimbursement methodology for Medicaid providers.	**9-17-13**	**9-17-13**

Budget Update/Medicaid Growth

Rick Platt presented the budget update. A copy of his report is attached to the minutes.

- Total enrollment for August: 260,344, an increase of 660 individuals, or 0.3%
- People over 65 increased by 19
- People with disabilities increased by 120
- Children increased by 369
- Pregnant women decreased by 102
- Adults increased by 254

We are expecting enrollments to go up in January because of ACA by 11.7%, while we expect general growth of 1.4%. Currently, both of these increases have been budgeted for and are funded.

Russ asked whether the ACA growth was due to CHIP expansion. Michael replied that the CHIP to Medicaid transitions are part of the 11.7% increase, however those children do not require new funding as they were already accounted for in the CHIP budget.

CHIP to Medicaid Transition Plan Update

Emma Chacon gave an update on the CHIP transition. UDOH has submitted the transition plan to CMS, and we have a call to discuss it with them. Eligible kids will switch over by March 1. We decided it would be best to transition by March instead of earlier because we'll still be working out kinks in January and February. CMS requires that we transition eligible kids no later than April. Mark Brasher asked whether EREP would be ready for the conversion. Emma replied that the transition process would be a very simple program to look at their current income and household size. A separate medical program was created within eRep to allow the transition to Medicaid to occur while preserving the review periods. As each child's review is due, DWS will then perform a full eligibility evaluation. As a result, it may be possible for a child to return to the CHIP program depending on their family's income.

We have drafted the first general notice to all CHIP families. It will go to plan A and plan B families, encouraging families to start looking at what the changes will mean for their family. While many physicians provide services for both CHIP and Medicaid clients, it will be important that families check as well as verify that they are contracted with the ACO they prefer. These notices will go to families next week.

Lincoln asked whether Emma has worked with Dr. Cosgrove to reach out to providers. Emma said that was the next step. The letter also informs families of changes in dental and behavioral health services. This may be the most difficult step for families in the transition.

We will send a second notice to specific families we believe will be impacted. They'll be informed that they'll have an opportunity to choose a health plan and a dental plan after the New Year. We'll be sending plan info in December for March enrollment. Russ asked whether the health plans could get a copy of the notices. Emma said they will get one, and Summer will send a copy to MCAC with the minutes. We'll also look at innovative ways to get the information to providers.

Lincoln asked whether we're working with the PMHPs to prepare them for CHIP transition. Emma said that the counties have asked for the numbers of kids we might be talking about. We should be sending those numbers fairly soon. Lincoln asked whether there would be capacity issues. Emma replied that there were none anticipated.

Quality Measures Workgroups

Emma gave a report on the Quality Measures Workgroups. The contract amendment on the 25 HEDIS quality measures has been signed and the plans are moving forward with implementation. The next quarterly meeting of the ACO Quality Measures Workgroup is November 7 at 1:00 in room 128. The State Quality Committee will be meeting on October 1 to discuss the initial recommended behavioral health measures to review possible measures for clients with complex health care needs. We've had

stakeholders meet to discuss and come up with recommendations, then used the State Quality Committee to get down into the details of how measurements should be made.

The state has been working with the Division of Substance Abuse and Mental Health on the Integration of Health and Behavioral Health Initiative. We need to start at the basics—getting the systems to work together and understand each other. We are working with the division to set up a training, workgroup, and meet & greet with all of the supervisors and managers from both systems—ACOs and PHMPs. That will happen November 1. We are inviting the director of the SAMHSA Center for Integrated Health Solutions to speak to the group. The purpose of the meeting is to outline the as-is system and how we can improve it. We will have similar meetings with care coordinators later on.

Emma reported on quality measures for clients with special health care needs. Andrew set up a call with an organization in Massachusetts (Commonwealth Community Care) that integrates care for these individuals. The state will be looking at the results of that call and putting together some recommendations.

Advanced Practice RN Billing Policy

Michael Hales gave a report on potential changes to the Medicaid billing policy for APRNs.

Medicaid currently allows only four types of APRNs to bill as Medicaid providers: Pediatric Nurse Practitioners, Family Nurse Practitioners, Certified Nurse Anesthetists, and Certified Nurse Midwives. It is required by the federal government that those four classifications be able to bill Medicaid directly. All other APRNs need to bill under a supervising physician's information. As we are contemplating what Medicaid expansion could do in terms of additional individuals coming into Medicaid (potentially 125,000 new individual), we are looking at whether we will have enough providers. Our current projections are to have 30-50k new individuals on Medicaid in the first 6 months of 2014, regardless of what decision we make in expansion. The adjustments to asset tests, the 'culture of coverage' and tax penalties for the uninsured would be the drivers of this increase. Also, in the ACO model, we are trying to focus more on quality outcomes than billable services, but a provider still has to be registered with Medicaid in order to bill for care. There's a potential for looking at how we deliver care and making sure we have physicians take care of more acute needs, with mid-level providers taking care of others. We're trying to look at ways to use the capacity within the healthcare system to provide appropriate care. Our staff has prepared a report on the pros and cons of allowing all licensed APRNs to bill directly for services within their scope of practice. This is primarily a challenge in the fee for service element, but there is a challenge even among ACOs to have APRNs recognized in the encounter data because providers still must be registered with Medicaid. Lincoln mentioned that some of the FQHCs are run by mid-level providers and asked how that could work. Michael replied that Medicaid accepts billing from the four types of nurse practitioners mentioned. Michelle asked how the billing works on the commercial side. Russ said he thinks they can bill independently.

Michael said that one of the other elements to payments has been a review of what surrounding states and private insurances pay. Sometimes all APRN's are compensated at 100%, but Certified Nurse

Midwives were often reimbursed at 75%-90% of the fee schedule. DMBA and PEHP had an 85% reimbursement while Altius was at 75%. Medicaid's proposal would be for 75% as well.

Lincoln said it's still not clear what the obstacles are. Can the state just do this by rule? Michael replied that we would have to change our State Plan, get CMS approval, update our state administrative rule, update provider manuals, update our billing system, then begin enrolling the new providers. Give the historical circumstances and looking at the mandate, this is one of the ways the agency is trying to ensure that we don't have a provider shortage. Michelle asked how the new rule would change billing for physician offices where NPs are already on staff. Michael replied that APRNs could still bill under the physician if they chose to do so, but this would allow NPs to be independently credentialed and bill on their own in order to enhance capacity. Michelle expressed her preference that APRNs still be allowed to bill under a supervising physician. Michael said that was achievable. Andrew asked whether the state has run any numbers to get an estimate of how many providers they would be able to attract at 75% reimbursement. Will that be sufficient to meet the need? Michael stated that the only work we've done on that is to survey other states' plans. If we move forward as proposed, we'd see how it worked and see later whether we need to make a change. Lincoln pointed out that ACOs could have the flexibility to reimburse as they chose. Michael said that he hoped this rule would alleviate any hurdles to using mid-levels in an ACO model. He confirmed that the ACOs could reimburse at the level that worked for them, provide savings-sharing payments, etc. The specific level of 75% would apply to the fee-for-service community, which applies mostly off the Wasatch Front. Russ asked how many NPs are Medicaid providers now, and how many we expect to gain. Michael said that a lot of the volume of NPs are invisible to us because they're billing under a physician. Danielle Pendergrass, who was in the audience representing Nurse Practitioners, said that there are 748 NPs are currently billing Medicaid directly and 338 who are billing under a supervising physician. We have about 1,400 NPs in the community.

Michelle recommended that we begin with reimbursement comparable to what other states/private insurance are doing and adjust from there. Michael said that we do pay 100% to certain NPs. We would not change the reimbursement for the current categories. Andrew asked what the basis was for the rate differential between the categories. Michael replied that he did not know why the Certified Nurse Mid-wives were paid less. Jackie suggested we look at making the reimbursement equal among the categories. Michael then commented that after analysis, perhaps some set amounts (ex. 95%) could be paid to avoid this disparity. Lee Moss, who was in the audience representing the American Association of Nurse Practitioners, said that Medicare reimburses NPs at 85%, with 100% for CNMs and asked if this could be done for Medicaid. Michael commented it was not possible for Medicaid to raise rates equivalent to that which Medicare pays. The point made was then clarified to mean that APRN's could all receive reimbursement of 85% (or whatever percentage was agreed upon).

Lincoln then made a motion to recommend that the Department move ahead with allowing mid-level clinicians to which Andrew added that additional discussion on the rates is required. Russ seconded the motion and it was approved.

PCP/VFC Enhanced Rate Update

John Curless gave a report on enhanced reimbursement. On the fee-for-service side, we have paid to date, for quarters 1 and 2, a total of $1.6 million. Due to payment adjustments required, a total of $20k in quarter 1 was retracted with $311k paid to replace. In addition, for quarter 2, $437k was retracted with $527k paid in its place. This method of full credit/debit is necessary as the state is required to show a single payment for each quarter. It is not a physical recoupment, but is documented this way.

The reason for this occurring was due to a nuance with how the data was pulled from the system in instances where both the billing and servicing provider were the same. During initial processing, more emphasis was placed on reviewing providers for board certification then the 60% coding requirement. This may have meant for a provider that did not complete their verification of board certification timely that the Division had to wait until their coding was reviewed which may have made them eligible, potentially for the entire previous quarter. Michelle asked how many providers were found eligible. John replied that 330 providers in Q1 and 428 in Q2 for fee-for-service. As for servicing providers, there were 740 in Q1 and 1,155 in Q2.

On the ACO side, as of our reprocessing this weekend, there is no money that has been paid to the ACOs at this time. We found that we had encounter records that were missing in our data warehouse, which have now been corrected, as well as some duplicate records. There have also been some external issues with the data submitted by the plans. For example, some 'paid amounts' and 'TPL amounts' on many records were showing the same total. The plans with data issues are working to get those encounters corrected and resubmitted. We will be making payments in Q3 for all of this calendar year. The plans will have 60 days from the time we make the payment to get the provider paid. The amount we pay is not necessarily the amount they pay to the provider. In theory, ACOs could get a windfall depending on the payment differentials, although it is unlikely to occur. Michelle asked if any providers have received any payments at this time from the ACOs. Russ explained that without the funds received by Medicaid as of yet that the plans do not have anything to forward on at this point in time. John added that 2 plans are likely to receive reimbursement soon for the first two quarters.

There is also an issue with Medicare crossover indicators, so we will be working with the plans that have issues with that on an ongoing basis. We won't hold payments up for that, but those payments will reprocess for the next quarter.

John then talked about the difference in enrolled physicians. As of June 30, 2012, there were 27,829 physicians, osteopaths, and group practices enrolled in Medicaid. On December 31, 2012, there were 29,095, on March 31, 2013, there were 29,379, and on June 30, 2013, there were 29,554. Michael and Michelle pointed out that there are less than 14,000 physicians in the state. John said that some providers and practices are enrolled more than once due to multiple locations and different services and the net change may be of more interest than the totals provided. Michael added that the physician's motivation for contracting with Medicaid is still not known. It may be due to the enhancement, or it may be due to the ACO adjustments requiring all physicians to be known and enrolled with Medicaid.

Michelle said that the bump in payment won't attract a ton of providers because it's temporary. She suggested that Medicaid make the enhanced payments ongoing. William Cosgrove asked whether it's possible to get the data back for his own practice so they can cross-check it against the ACOs. Dr. Cosgrove said that he wants Medicaid to look like it is easy and fair, but the physician perception is that it's complicated and messy. He's looking for as much transparency as possible so providers will want to be a part of Medicaid. John said that he's had requests for detailed payment data by individual practices, and the data has been provided. Michelle asked whether we could provide this data automatically. Michael said that if we had an e-mail for all of the offices, we could run the report and email it. For those who don't have an email on file, we could get an email address or continue to provide data on request only.

Medicaid Expansion Workgroup Update

Nate Checketts gave an update on the Medicaid Expansion Workgroups. They met on Sept 5. They have submitted fact sheets to the Department, and they will be presenting them at the Governor's Healthcare Summit on the 26th. MCAC members have a complimentary registration to the Governor's Health Summit—contact Victoria Brimhall at vtatum@utah.gov to claim your ticket. We will have legislators talking to us about expansion experiences in their states. We will have an overall report from the workgroup. The Governor will not announce a decision at the summit. He will make a decision during the legislative session.

Health Plan Joint Outreach Efforts Update

Russ gave a report on the health plan joint outreach. The MCAC decided last month that a subgroup would be part of the process of creating the outreach materials. Russ asked the state to clarify what MCAC's role is. Emma replied that the Division has final approval, but would like the MCAC to review and advise. Lincoln asked whether the Committee would like to delegate the decision to the subgroup. Jackie Rendo thought that keeping the materials to the subgroup would work, then allowing anyone else interested to review as well. Emma suggested that the executive committee then review and report out which may help keep the process streamlined. Michael assured the group that there would still be an option for the larger body to voice concerns.

Michelle made a motion for the MCAC's process to follow that of the CHIPAC as discussed. Jackie seconded the motion and it was approved.

Emma added that the first flyer created was more for the navigator publicity and not necessarily regarding Medicaid or CHIP, however thought the process went fairly well. Summer will distribute the flyer with the minutes.

Update on ACA Eligibility Changes

Jeff Nelson gave a report on ACA implementation. We're 12 days away! DWS and Health started on this in March of this year. Jeff gave an overview of the changes to expect:

On October 1, there will be a new Medicaid and CHIP application. It has been approved by CMS. There may be further changes after that as we decide what's working and what is not. There's a whole new page in the application due to the tax filing information needed, even though we strive to keep the application short and simple.

The federally-facilitated marketplace will be live on October 1. Utah is prepared to work with the exchange, but they might not be prepared to work with us. We have not yet been able to test the capacity to send applications back and forth. We think we'll have some turbulence in the process with the exchange. We had a call yesterday with the feds and they said they believe they'll be able to enroll people for January 1. Michael mentioned that individuals have to enroll during the open enrollment period in order to be covered on January 1 and receive a subsidy. Also, DWS has to take applications and process them immediately, but if the individual doesn't qualify immediately, DWS has to re-run the application according to the rules that will take effect January 1. If the individual qualifies, he or she will be enrolled as of January 1. Lincoln asked whether we be able to enroll people in Medicaid through healthcare.gov on October 1. Jeff replied that we may run into problems from healthcare.gov. We may get duplicate applications. We may have long wait times and need to provide retroactive coverage. We won't have an accurate answer until October 1. Kevin said that if the application isn't tested October 1, we won't be telling people that the system works. Michael pointed out that there aren't subsidies available until January 1 anyway, but that's not as big a risk as a person trying to enroll in Medicaid. Jeff said that if there's a person who is likely to be eligible, it makes much more sense to try to get them to our agency. Kevin said that there is an optional rapid routing function that helps steer individuals rather to the DWS application or to the exchange by using four questions. The questions are available through jobs.utah.gov. The federal government has discussed the possibility of putting something similar on healthcare.gov.

Michael commended the efforts and accomplishments of the Department of Health, the Department of Workforce Services, and the Department of Technology Services. CMS has also commended us as well compared to other states.

MAGI programs are changing effective January 1. There will be no asset test. We are unique in our state in that we can run both the old and new rules at once. In October, we will be able to give clients both their current eligibility and their eligibility for January. Income limits will be going up for several programs. MAGI calculations make eligibility a little more transparent and easier for applicants, as opposed to disregards for particular expenses on specific programs.

We have a new mandatory Medicaid group for former foster kids—kids who age out of foster care in Utah can continue their Medicaid up to age 26.

We're changing the verification and renewal process for all Medicaid recipients. We will attempt to verify information electronically so we don't need to ask the client for documentation.

Presumptive eligibility: Hospitals will be able to issue a temporary Medicaid card to certain patients. Our goal is to have that ready by January 1. Andrew asked whether we would need additional resources to implement presumptive eligibility. Jeff replied that we probably will not. Kevin pointed out that the

individuals enrolling through presumptive eligibility aren't newly eligible individuals, but the presumptive eligibility process just provides a simplified application.

Dr. Cosgrove asked how family size would be determined for a family that has a fluid number of members. Michael replied that it will depend on how the family files taxes. This is meant to ensure families don't fall into multiple income categories.

Director's Report

Michael reported on a few other details:

CMS is willing to extend our 1115 waiver to allow PCN to remain longer than November. That's as much information as we have at this point.

We are moving forward to send plastic Medicaid cards that are good for the duration of an individual's eligibility. Tina, Jackie, and Andrew expressed a lot of enthusiasm for that change. Michael said that restrictions will not be printed on the card, nor will the other info. Providers will log in through a provider portal to get the rest of the information online. Providers can also use eligibility info from previous months.

Adjourn

With no further business to consider, the meeting adjourned at 3:50.